Washington State
Department of Social
& Health Services

Annual Payment Integrity Report for State Fiscal Year 2009

Prepared by the Health and Recovery Services Administration

State Fiscal Year 2009

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Executive Summary

> When the Federal Government makes payments…it must make every effort to confirm that ***the right recipient is receiving the right payment for the right reason at the right time*.** The purpose of this order is to reduce improper payments by intensifying efforts to eliminate payment error, waste, fraud and abuse in the major programs administered by the Federal Government, while continuing to ensure the Federal program serve and provide access to their intended beneficiaries.
>
> President Barack Obama
> Excerpt from Executive Order: *Reducing Improper Payments*
> November 23, 2009

The Department of Social and Health Services (DSHS) is Washington's umbrella agency for people who seek help in times of need. The mission of DSHS is to improve the safety and health of individuals, families and communities by providing leadership and establishing and participating in partnerships. Each year, more than 2.1 million children, families, vulnerable adults and seniors come to DSHS for protection, comfort, food assistance, financial aid, medical care and other services.

DSHS is the largest state agency in Washington State government and represents one-third of the state's overall budget. Annually, DSHS pays approximately 120,000 providers $5.6 billion for medical and social services for our recipients. DSHS takes our responsibilities as stewards of these public funds and programs seriously and strives to be accountable to taxpayers by verifying that correct payments go to the right provider for the right services. The largest DSHS expenditure is for Medicaid services for healthcare and long-term care services.

When discussing fraud, waste and abuse in the Medicaid program, it is important to remember that Medicaid is a jointly operated and funded program with the federal government financing approximately 57% of Medicaid nationally with the remaining funds coming from State general funds.

Consistent with Executive Order No. 13520 and the Improper Payments Information Act of 2002, which both focus attention on the reduction of improper payments by making financial management a high priority, DSHS has already implemented many of the highlighted strategies with impressive outcomes. **This report includes specific information and results related to data analysis activities, audits, investigations, referrals and administrative actions.**

State **Fiscal Year 2009 Highlights** include, but are not limited to, the following:

- Recovered $20,600,844 in taxpayer dollars from provider audit activities
- Increased by 100% referrals to the Attorney General's Office (Medicaid Fraud Control Unit)
- Completed procurement and initial design phases on the Second Generation Fraud and Abuse Detection System funded 100% by a Medicaid Transformation Grant
- Connected veterans on Medicaid to their federal veterans benefits saving Medicaid $4,856,885
- Saved $381,000,000 by identifying third party insurance responsible for medical bills
- Recovered Client/Recipient overpayment and fraud recoveries saving $48,770,156
- Terminated 24 Medicaid provider contracts based on billing and quality of care issues

Washington DSHS is a national leader in Medicaid fraud, waste and abuse detection and prevention efforts and continually strives to assess and improve our payment integrity efforts. A short summary of Washington State's leadership efforts:

Fraud and Abuse Control Technical Advisory Group (TAG). As part of the National Association of State Medicaid Directors (NASMD), HRSA Assistant Secretary (serves as Executive Committee Liaison) and the HRSA Deputy Assistant Secretary (Western Region voting member) participate in the NASMD Fraud and Abuse TAG which is a national forum for all Medicaid-related fraud and abuse control activities.

National Association for Medicaid Program Integrity (NAMPI). NAMPI is a national organization representing over 400 state, federal and vendor members in combined efforts to safeguard the fiscal, operational and program integrity of Medicaid programs. The HRSA Deputy Assistant Secretary has served on the NAMPI Executive Board for five years, the last three as President with Washington staff as presenters and attendees for many years.

Medicaid Integrity Program Advisory Committee. The HRSA Assistant Secretary and Deputy Assistant Secretary are both active members of the Centers for Medicare and Medicaid Services Medicaid Integrity Program Advisory Committee advising CMS on the wisest way to spend increased federal investments in Medicaid payment integrity granted under the Deficit Reduction Act. Participation led to the establishment of the Medicaid Integrity Institute discussed on page 16.

DSHS Payment Integrity – Pulling it all together

Coordination of Medicaid fraud, waste and abuse activities requires partnership with every DSHS administration entrusted with taxpayer dollars. Payment integrity is everybody's business. An Executive Steering Committee formerly sponsored by the DSHS Deputy Secretary and then the Chief Financial Officer, with staff support from the HRSA Payment Review Program, pulls the various payment integrity efforts together in a single forum. The Payment Integrity Executive Steering Committee meets quarterly to discuss issues, coordinate plans, and discuss the status of current federal and DSHS payment integrity efforts and to discuss and prioritize future areas of focus.

DSHS payment integrity efforts primarily focus on two areas[1]:

- Provider review and audit
- Client or beneficiary review

Provider payment integrity efforts are largely managed within the Health and Recovery Services Administration (HRSA) which operates Medicaid and other medical assistance, including the State's Children's Health Insurance Program (SCHIP). HRSA also includes the state's Mental Health programs, chemical dependency and prevention treatment programs. Within HRSA, the Office of Program Integrity (OPI) coordinates with stakeholders throughout DSHS programs including focused attention on social service programs.

The Division of Fraud Investigation (DFI) leads the agency's efforts related to the detection and prevention of client or beneficiary fraud. The DFI Director reports directly to the DSHS Chief Administrative Officer.

DSHS Provider Review Activities

Washington's Office of Payment Integrity (OPI) focuses primarily on three audit activities:

- Data Analytics and Reviews – including triage and referral
- Provider Self Review
- Onsite and Desk Audits

Data Analytics and Reviews

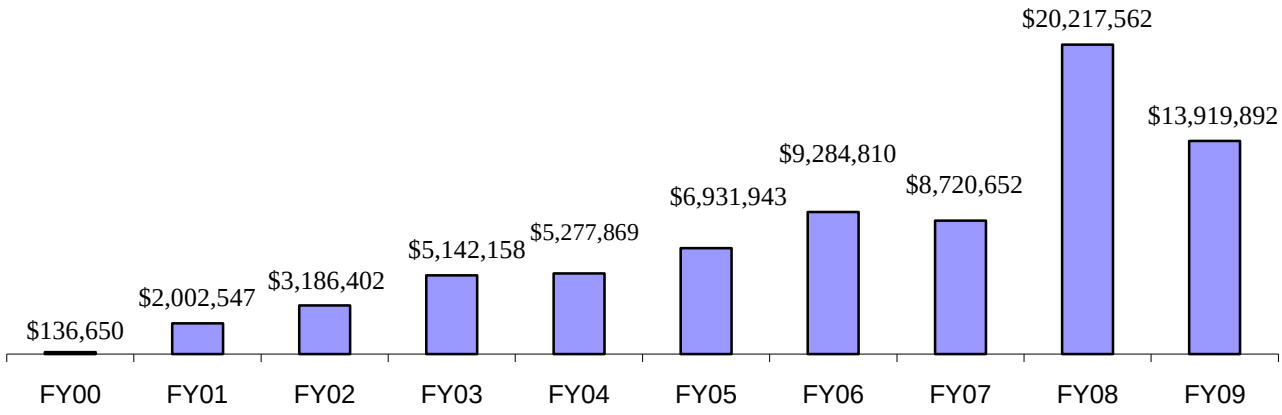
The Payment Review Program (PRP), a subsection of OPI, is nationally recognized for its progressive and innovative approach to the detection and prevention of Medicaid fraud, waste and abuse by using

[1] Staff fraud and payment integrity is primarily addressed within the individual administrations in partnership with the Human Resources Division

sophisticated technology and data mining techniques recovering millions of dollars a year through data analysis alone.

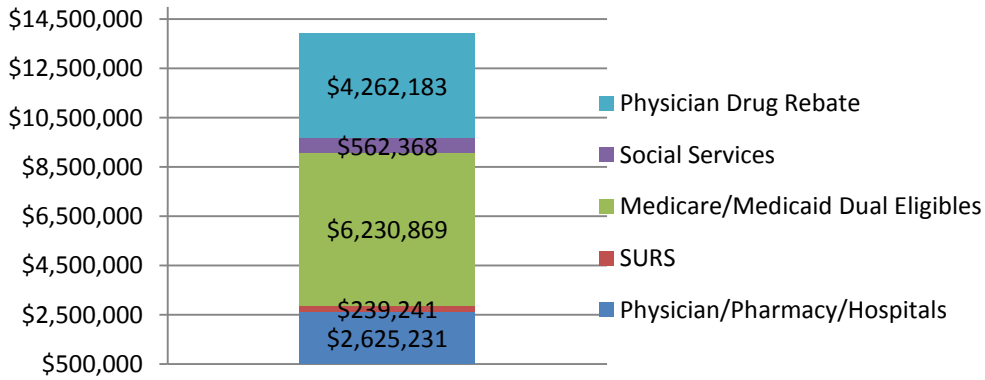
- Overpayment identification: PRP utilizes complex algorithms, modeling and data mining techniques to review claims and to detect overpayments and potential fraud, waste and abuse in Washington's two large Medicaid payment systems that pay both medical and social services;
- Prevention: Following the identification and recovery of inappropriately paid dollars, DSHS implements system edits or policy changes where possible, to prevent future inappropriate payments.

PRP Savings by Fiscal Year[2]



Note: FY08 savings increased when PRP assumed one time historical overpayment recovery for Medicare/Medicaid dual eligibles

Breakdown of FY09 $13,919,892 Savings Results



[2] *Algorithms identified aberrant billings from a variety of DSHS providers including Dentists, Physicians, Hospitals, Pharmacies, DME suppliers, Family Child Care Providers, Adult Family Homes, Supportive Living Providers and Home Health Providers*.

Sophisticated data systems. The Payment Review Program's success in data analytics relies on the use of sophisticated technology systems allowing access to data and turning data into powerful information. ***Implementation of the initial Fraud and Abuse Detection System (FADS) back in 2000 has resulted in over $74.8 million in savings plus increased savings through improved audit support.*** These successes were the result of strong partnerships built across DSHS administrations/divisions and collaboration with system contractor. However, future opportunities exist.

The ProviderOne payment system implementation will provide more robust pre-payment edits and automated audits that protect dollars before they go out the door. Further, with Phase 2, DSHS' two large payment systems will merge into one allowing, for the first time, to automate checks across systems. For example, ProviderOne will ensure that both a hospital and in-home care providers are not billing for services to the same client on the same day. An upgraded payment system will significantly enhance payment integrity.

Second Generation Fraud and Abuse Detection System (FADS)

In 2007, DSHS applied for and was awarded a $5.9 million dollar federal Medicaid Transformation Grant. The goal of the Project is to design and develop a state-of-the-art FADS building upon the success of our existing system. The Second Generation FADS implements in the summer of 2010 and brings the following new areas of focus:

- New methods for detection and prevention of fraud; waste and abuse in Medicaid Managed Care; DSHS client fraud; employee fraud; Mental Health and substance abuse data reviews and audits
- Automated alerts and spikes in provider billing patterns
- Geo-mapping capabilities
- Comprehensive Case Tracking for provider and client cases (in partnership with the Division of Fraud Investigations)

Triage and Referral Process

A specialized team, called Surveillance and Utilization Review, within OPI, generates profiles based on billed claims and utilization patterns of Medicaid providers. By analyzing and comparing providers to their respective peer groups, abnormal patterns are identified and appropriate follow-up action is initiated which could include, but is not limited to: referring the provider for an audit, fraud investigation, or quality of care review. This team also receives and investigates constituent referrals received through DSHS' hotline – 1-800-562-6906 or e-mail address HotTips@dshsmsg1.dshs.wa.gov.

Provider Self Review

Washington is a national leader in its use of a voluntary Provider Self Review Program which invites providers to review claims identified by DSHS, which have the potential to be improper billings. Washington DSHS' traditional data mining tools worked well but there were instances where using the data alone could not

The January 2009 edition of the "Medicaid Compliance News" featured Washington State's pilot of the Provider Self Review Program

positively identify overpayments or billing patterns that warrant audits. After providers complete their on-line review they submit the information to DSHS who then reviews a random sample of their documentation. DSHS will then generate an overpayment notice to the provider on any of the improperly billed claims. Advantages of participation in the Provider Self Review Program for providers include:

- Reduction of administrative burden and efficient use of time for both providers and state staff
- Enhance providers' existing audit and compliance review programs
- Eliminate/reduce interest penalties – no interest is calculated for 90 days after an overpayment is identified

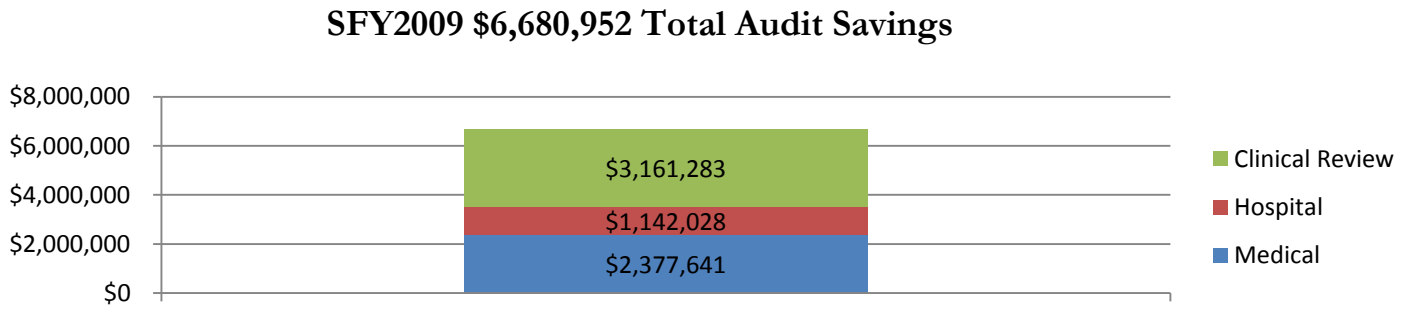
Onsite and Desk Audits

To further ensure that Medicaid payments are made in accordance with federal and state regulations, DSHS audit staff perform both on-site and desk audits of Medicaid providers – both medical and hospital providers.

Medical Auditors conduct post-payment reviews and audits for noncompliance with applicable program rules and regulations for licensed medical professionals, pharmacies, family planning clinics, dentists, and durable medical equipment providers. Audits may be conducted as full onsite compliance audits at the provider's place of business or they may be conducted as a desk review. Medical auditors also conduct pharmacy third party liability (TPL) audits to ensure that Medicaid is not paying for prescriptions that should be covered by another insurer.

Hospital Auditors conduct post-payment reviews and audits for noncompliance with applicable program rules and regulations for inpatient claims, outpatient claims and hospital credit balance reports.

Prepayment Clinical Reviews. Clinical Review Nurse Auditors conduct pre-payment and post-payment reviews to ensure services were medically necessary and billed correctly by applying nationally recognized clinical guidelines. The pre-payment reviews are for claims on clients who are readmitted to a hospital within seven days of being discharged from the hospital. These reviews require review of the medical and billing records associated with the claim to insure the inpatient hospital admission is appropriate.



Other DSHS Provider Payment Integrity Efforts

Payment integrity is everyone's business. Beyond formal fraud, waste and abuse prevention and detection activities are efforts such as:

- Ensuring the appropriate quality of care is delivered
- Employing careful admissions of providers into the Medicaid program and swiftly terminating the contract of any provider endangering the health and safety of our clients
- Ensuring Medicaid is the payer of last resort and ensuring that third party insurers make payments where appropriate
- Promoting evidence-based purchasing and utilization controls through prior authorization

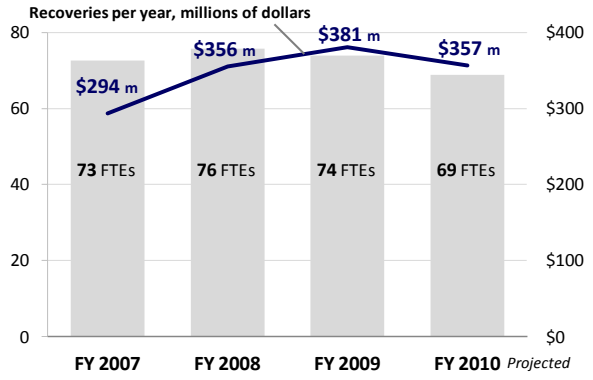
DSHS Quality Management Team (QMT) ensures the effective and equitable management of complaints regarding the quality of care provided to medical assistance clients in the fee-for-service and managed care programs. QMT staffs and presents cases to the Medical and Dental Advisory Committee.

DSHS Medical and Dental Advisory Committee (MDAC) meets monthly to review new Medicaid provider applications or providers referred to them for review by QMT. MDAC is composed of voting members from a variety of program areas including the Medical Director, clinical consultants, mental health, alcohol and substance abuse, quality of care, dental administrator, pharmacy, and payment integrity. In State Fiscal Year 2009, MDAC:

- Terminated 12 Medicaid contractors
- Denied 13 and Approved 41 applications to become Medicaid contractors
- Terminated 12 Medicaid contractors due to suspended, revoked and expired licenses

Coordination of Benefits (COB)

The Coordination of Benefits unit in HRSA identifies Third Party insurance and is a critical component of DSHS' cost containment efforts. By federal law, Medicaid is the payer of last resort. If other insurance exists, it should cover medical expenses before Medicaid.



*In State Fiscal Year 2009, Coordination of Benefits saved the state almost **$381,000,000** in cost avoidance and recoveries*

Authorization Services Office (AS0)

The Authorization Services Office is responsible for processing prior authorization requests from providers for the following services: Dental, Durable Medical Equipment, Pharmaceuticals, Medical Procedures, Hospice, Alien Emergency Medical, and Enteral Nutrition. The prior authorization process involves the implementation of system edits that trigger a review of requests for client safety, medical necessity, and cost avoidance. The cost avoidance component by percentage of requests denied is listed below, cost savings is currently being calculated for 2009:

Dental	DME	Medical	Pharmacy
32%	13%	30%	26%

DSHS Payment Integrity Partners

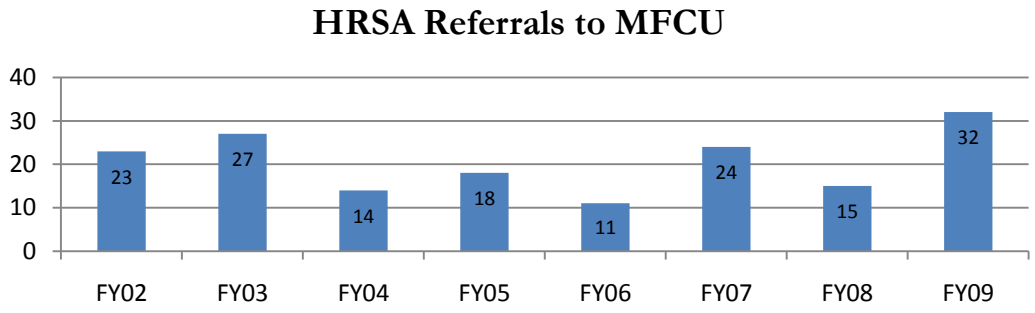
Office of the Attorney General, Medicaid Fraud Control Unit

The Attorney General's Office Criminal Justice Division houses the Medicaid Fraud Control Unit (MFCU). MFCU investigates and prosecutes Medicaid provider fraud. DSHS refers all suspected cases of Medicaid provider fraud to MFCU for follow-up. DSHS maintains a high level of cooperation and coordination with MFCU and meets monthly to exchange/request information on cases and to review all pending or potential provider referrals.

Federal Fiscal Year 2008 Statistical accomplishments for Washington MFCU are as follows (please note that these statistics cover FFY2008):

- Convictions: 21
- Total Recoveries: $17,956,307
- Civil Settlements: 7

In State Fiscal Year 2009, HRSA increased referrals to MFCU by 100% over the previous fiscal year and achieved the most referrals since SFY2002.



HRSA Steering Committees/Workgroups

HRSA has formed steering committees which focus on various Medicaid program areas such as provider enrollment, pharmacy, licensed health care professionals, facilities, durable medical equipment (DME) suppliers and contracted services. These Steering Committees bring multi-disciplinary teams together to identify, discuss, and agree on data driven strategies to best manage and protect Medicaid program

funding. The Steering Committees utilize data and other tools to assist HRSA in evaluating risk and making data driven policy decisions.

These forums are used as an opportunity to:

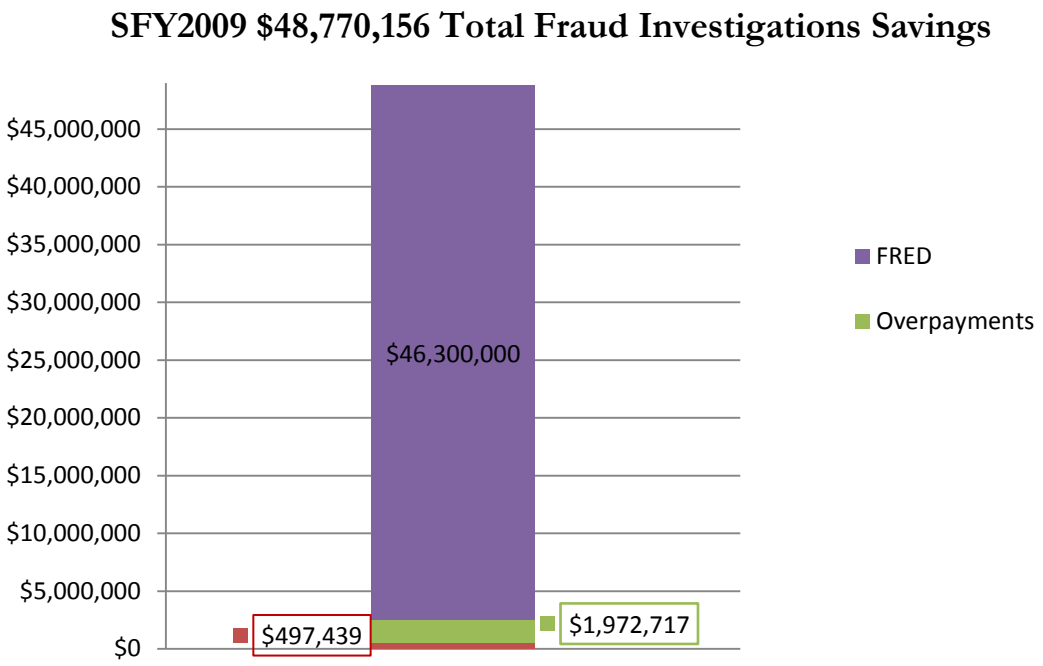
- Educate state employees of their responsibility to contribute to payment integrity
- Influence policy makers, prior to adoption of policies, to consider the affect they will have on DSHS' ability to audit and hold providers accountable to them
- Provide an important feedback loop on how DSHS policies are actually being implemented by Medicaid providers

DSHS Client Review Activities

Division of Fraud Investigations (DFI)

Within DSHS, the Division of Fraud Investigations (DFI) has delegated authority to conduct investigations related to allegations of fraud within programs administered by the Department of Social and Health Services. Investigations focus on Welfare eligibility issues and client fraud. Investigators coordinate with staff at the Community Services Offices statewide; county prosecutors; two United States Attorneys' offices; and with local, state, federal, and international law enforcement agencies when necessary. DFI consists of three units:

- Fraud Early Detection Program (FRED) focuses on changes in client's eligibility to receive DSHS programs. In SFY09, FRED validated that 8,897 cases had eligibility/benefit changes which resulted in cost avoidance of $46,300,000.
- Overpayment Unit issued 219 overpayments to recipients who intentionally accepted overpayments in the amount of $1,972,717.
- Criminal Investigations Program (CI) focuses on fraudulent cases. In State Fiscal Year 2009, CI referred 129 cases to prosecutors who reported back on the disposition of 107 cases: 47 convictions, 6 diversions, 20 dismissals (usually after completing a successful diversion) and 34 declines. Restitution in the amount of $497,439.



In State Fiscal Year 2009, DFI and HRSA payment integrity staff began to partner on developing a new case tracking system which will be used for both provider and client fraud; and waste and abuse cases. During these conversations, staff gained a greater understanding of the interdependence these programs have on each other and have committed to working together in State Fiscal Years 2010 and 2011 to develop data analytics that can be used by staff to target areas of interest.

Veterans Benefit Enhancement Program

Many low-income U.S. military veterans and their families rely on Medicaid, and may not realize they are eligible for comprehensive federal health care and benefit programs that would provide better benefits while preserving their homes and financial assets. Washington State's Veterans Benefit Enhancement Program staff embarked on a pioneering effort to using available federal data to connect Medicaid recipients with their federal veteran's benefits.

Washington began its efforts in 2003, focusing on long-term care beneficiaries, most of them in nursing homes, and working in partnership with the Washington State Department of Veterans Affairs. Since then, the state program has become national model and best practice for using federal veteran's data.

The program is of benefit to veterans and results in redirection of Medicaid funding to others in need. The program is committed to building upon the over $13 million in savings since its inception.

During SFY2009, through Veterans Benefit Program efforts the department connected:

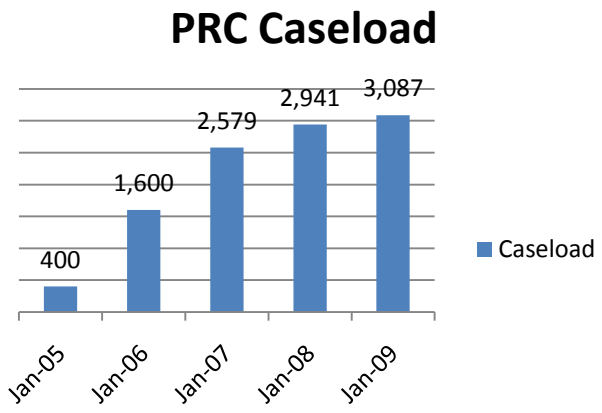
- 506 Medicaid recipients with their VA Health Care coverage

- 1,207 Medicaid recipients with their military or veterans civilian health insurance coverage (TRICARE or CHAMPVA). Cost avoidance[3] in the amount of $1,868,380
- 343 Medicaid long-term care recipients were awarded new or increased VA monetary benefits
- Cost avoidance[4] in the amount of $2,988,505

Patient Review and Coordination (PRC) program

Washington State's Patient Review and Coordination (PRC) program was established for more aggressive supervision of clients who need assistance with safe and appropriate medical services. The PRC program is able to limit participating clients to a single selected or assigned primary care provider, pharmacy and non-emergent emergency room services. This coordination of care helps to avoid duplication of services and excessive or harmful use of prescription drugs.

Caseload has grown over the past five years from a few hundred clients to more than 3,000 with annual savings currently based on a 2006 study of average per-client costs.

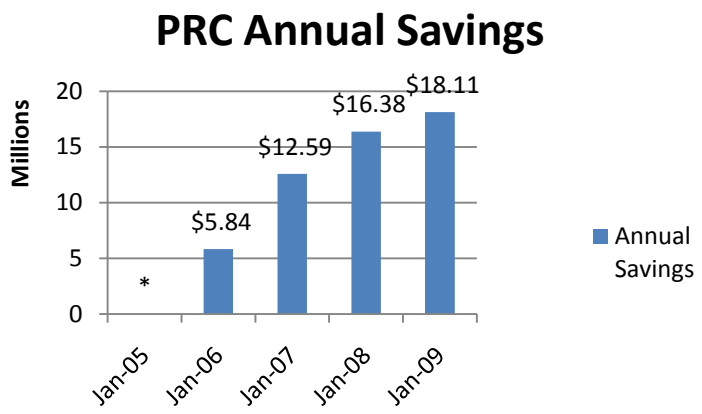


*"There are a few ideas out there. True, they don't add up to the billions of dollars that some state budgets are short. Just a few million here and there. But, two programs — one in the state of **Washington**, the other in Pennsylvania — are based on sound principles and actually stand to improve care."*

March 2008, Governing Magazine article
Medicaid's New Math

[3] Reduction/adjustment of Pharmacy, Medical and/or Institutional claims reimbursements; or cessation of HMO premium payments to *Third Party Liability*

[4] Reduction in Long Term Care payments (both Institutional and Home-and-Community-Based) due to increased VA monetary awards



Federal Program Initiatives

The Deficit Reduction Act (DRA) of 2005 established the Medicaid Integrity Group (MIG) that provides:

- Support and Assistance to States through periodic Medicaid Program Integrity Reviews (every three years) and State Program Integrity Assessments (SPIA)(annually)
- Federal contracts with "Medicaid Integrity Contractors" called MICs that audit state providers
- Technical Assistance to States by establishing the Medicaid Integrity Institute

State Fiscal Year 2009 was an eventful year for Washington State and their involvement in these federal initiatives. DSHS staff has expended great energy and time assuring that all data requested and submitted to the different federal entities and contractors were timely and accurate.

Medicaid Integrity Group Contractors

MIG has hired a series of contractors to audit state providers who receive Medicaid dollars. These auditors primarily perform data analysis and desk auditing activities. It is critical that state and federal government officials carefully coordinate audit activities to avoid redundancy and overlap.

In State Fiscal Year 2009, Washington participated in a pilot initiative with CMS contractor Catapult Consultants, Inc. Washington payment integrity staff provided education to the contractor on Washington State Medicaid audit and payment policies and procedures. Catapult Consultants, Inc. conducted eight (8) audits on DME, physician and dental providers. DSHS staff reviewed all draft reports and issued final reports on all the audits, and coordinated with DSHS legal counsel and providers for audits in administrative appeal status. Four out of the eight audits requested an administrative appeal. Total dollars identified in the eight audits: $823,208.

Program Integrity Review

Washington participated in a federal Program Integrity Review during SFY09 which covered the time frame of Federal Fiscal Year (FFY) 2008. Washington Program Integrity staff provided comprehensive policy and data that responded to the review and participated in an on-site review. Results will be received during SFY2010 and Program Integrity staff will develop corrective actions to respond to any program integrity weaknesses that are identified

State Program Integrity Assessment (SPIA)

In State Fiscal Year 2009, DSHS collected and submitted data requested for the annual SPIA which covered the time frame of FFY2007. The initial notification of collection of SPIA data was received by DSHS in September and the submission of the data was due at the end of November. The data collection entailed gathering statistical data regarding enrollment figures, staffing costs, provider enrollment and termination figures, and overpayments identified and collected through data mining and audit activities, among other content areas.

*The OIG reported that **Washington** State's 1% variance - between the PERM universe data and the CMS-64 report - was the smallest variance of all the states reviewed*

Payment Error Rate Measurement (PERM)

The federal Payment Error Rate Measurement (PERM) program was established to measure improper payments in Medicaid and Children's Health Insurance Program (CHIP) and produces state and national-level error rates for each program. PERM was developed by CMS to comply with the Improper Payments Information Act (IPIA) of 2002. The national PERM Program utilizes a 17-state rotation so that each state is reviewed once every three years. Washington was one of 17 states measured for Federal Fiscal Year 2008.

For the PERM measurement, Washington compiled data from all DSHS payment systems that pay claims with Medicaid funding which for DSHS included about 17 different data sources. Significant efforts were made to ensure all claims and payments with Medicaid funding were submitted in the data universe. This research paid off in June 2009 when auditors from the Office of the Inspector General (OIG) visited Washington and reconciled the CMS-64 with the PERM universe. The OIG reported that they reconciled the PERM universe to within 1% of the CMS-64 which was the closest of any state reviewed. Washington continues to be an active participant on the National PERM Technical Advisory Group conference calls to refine and improve the PERM process.

Medi-Medi Project

Medi-Medi was developed as a state-federal partnership that matches Medicaid and Medicare data to identify improper billing and utilization patterns and detect potential fraud and abuse. Since November 2004, Washington participated in a Medi-Medi Pilot. We were eager to partner with CMS on this Pilot Project because we recognized the potential that the availability of Medicare and Medicaid claims data together provided. Unfortunately, after four years of participation, Washington State had a negative return on investment and withdrew from Medi-Medi during FY2009 so that those resources could be

devoted to achieving the Department's positive return on investment in other payment integrity initiatives. Washington will continue to work with CMS to improve and redesign Medi-Medi to become a program with a positive return on investment for both state and federal partners.

Medicaid Integrity Institute (MII)

The Medicaid Integrity Institute (MII) was established in 2007 by the CMS Medicaid Integrity Group as the first national Medicaid program integrity training program. The mission of the MII is to provide training to meet the needs of state Medicaid program integrity employees with the goal of raising national program integrity performance standards. Washington State's HRSA Deputy Assistant Secretary participated in the formulation of the curriculum for MII and was instrumental in the adoption of federal legislation that allows federal money to pay for all state staff expenses to participate in the MII. The HRSA Assistant Secretary and Deputy Assistant Secretary are active faculty members at the MII.

A total of eleven (11) Washington state staff have attended MII training and have returned to Washington with new ideas and techniques for identifying fraud, waste and abuse in Medicaid programs. Even better than the ideas they brought back, staff return to Washington energized and with a list of colleagues they can network with as they perform their daily work. An auditor who attended MII's Certified Coder Boot Camp program used her training and passed the test to become a nationally certified coder. This has strengthened the auditor's accuracy in reviewing CPT codes and identifying inappropriately billed services.

Additional Information

For additional information about this report, please contact us at (360) 725-2113 or via e-mail Heidi.RobbinsBrown@dshs.wa.gov.